بسم الله الرحمن الرحيم

عنوان المحاضرة: Transverse Lie
تاريخ المحاضرة : 18/3/2013
المحاضر :د. محمد هاني

Definition: The long axis of the fetus is across the long axis of the mother
**The lie may be also oblique, head lower than breech is more often
Incidence: 1/1000
Etiology:
A) Fetus: 1-Prematurity 2-Multiple pregnancy (e.g. Twins) 3-Polyhydraminos 4-IUFD 5-Short Cord
B) Mother: 1-Contracted Pelvis 2-Pelvic Tumor 3-Placenta Previa 4-Pendulus abdomen 5-Multiparity
6-Congenital Anomalies (e.g. Bicornuate uterus)
*So, Any primipara with transverse lie→ Hysterosalpingography
**The Commonest cause of Transverse lie is (Multiparity), then Congenital anomalies
Diagnosis:
A) During Pregnancy: (Abdominal Examination ONLY)
Inspection: 1-Abdomen is broader from side to side 2-Fundal level is less than period of amenorrhea
Palpation: 1-Fundal Grip: (palpation of upper abdomen with both hands) is Empty
2-Umbilical Grip: can't determine fetal back, as head is on one side & breech is on the other
3-First Pelvic Grip: No presenting part in the pelvis
Auscultation: -Fetal Heart Sounds: heard on the side of the head
**The Denominator (chosen point used in describing position of the presenting part) is Shoulder
*There are 4 positions of transverse lie:
1-Rt Scapulo-anterior 2-Rt Scapulo-posterior 3-Lt Scapulo-anterior 4-Lt Scapulo-posterior

B) At Labor (Same Abdominal + Vaginal):
1-Slow dilatation of the Cervix 2-Bulging of the water bag
3-Premature Rupture of the membrane 4-Prolapsed cord
5-Trials of vaginal delivery (عن طريق الدايتة) may lead to → presenting arm → Obstructed labor
- في حالة الـ Prolapsed Cord لازم الولادة تحصل في خلال 10 دقايق وإلا الطفل هيموت
Mechanism of labor: -NO Normal Mechanism, ONLY Cesarean
**Small fetus (IUFD) may have: -Spontaneous expulsion: (fetus compressed as letter V)
-Evolution: (overstretching of neck)
Treatment:
A) During Pregnancy: after 38 wks
1-US: -Confirm diagnosis -Determine site of Placneta -Exclude Anomalies -Detect Maturity
2-External Cephalic Version:
**Not under anesthesia, to detect Uterus rupture, may use Tocolytics→ ↓Uterine contractions
**In the Operating theatre: so
- If version succeeded apply abdominal binder and rupture the membranes & deliver vaginal
- If failed or any maternal /fetal distress → Cesarean Section

B) During Labor:

1-Intact membrane (preserved amniotic fluid): → External Cephalic Version

2-Ruptured Membrane: → Cesarean Section

Neglected Shoulder: الداية

Same picture as obstructed labor:

History: 1-Prolonged labor 2-Strong & frequent uterine contraction

3-Rupture of membrane & leakage of amniotic fluid

Examination:

-General (Maternal distress) -↑Pulse -↑BP - Sweating -Signs of dehydration (1st Sign)

-Abdominal (like peritonitis) -Uterus: Tender, Hard, medial part not felt, moulded around fetus -No FHS

-Vaginal: -Swollen vulva -Dry & warm vagina -Edematous Cervix -Arm or Cord may be presented

Management: Cesarean section (Decapitation hook is obsolete)

Cord Prolapse & Cord Presentation:

***In both conditions a loop of the cord is below the presenting part. The difference is in the condition of the membranes; if intact it is cord presentation and if ruptured it is cord prolapse. (MCQ)**

-As long as the membranes are intact there is no risk.

In cord prolapse, the fetal mortality is 20-25% mortality from asphyxia due to:

-Mechanical compression of the cord between the presenting part and bony pelvis

-Spasm of the cord vessels when exposed to cold or manipulations

Types of Cord Prolapse:

1-Overt: protrusion of the cord in advance of the fetal presenting part الخلاص قبل الطفل, through the cervical os and into or beyond the vagina. The fetal membranes are ruptured and the cord is visible or palpable on examination.

2-Occult: the cord descends alongside, but not past, the presenting part. It can occur with intact or ruptured membranes. It often cannot be diagnosed with certainty, but is suggested by clinical features (eg, fetal bradycardia).

لما تكون الحالة متأخرة في الولادة (نتيجة إن رأس الطفل مكبستش على الـCervix) تعمل Rupture للـMembrance علشان تسرع الولادة (طبيًا مش صح ولكن ده طريقة للعيادات) ، بس لازم تعمل حاجتين مهمين جدًا:

1. بعد ما تفتح الـMembrane باستخدام الـartery تفضي الـAmniotic fluid تدريجيًا
2. تقعد جنب الحالة وتتابع الـFHS باستمرار

Management of both:

-If cervix is incompletely dilated → Cesarean section

-If cervix is completely dilated → Immediate vaginal delivery if Cephalic or Breech

but if Transverse lie → C.S.

***What to do in a case of Cord Prolapse at Emergency Department:**

Overt prolapse الخلاص قبل الطفل

1-Feel cord pulsations in-between uterine contractions with your other hand on the mother's pulse (to differentiate it from pulsations transmitted from mother to dead fetus) تميزه من نبض الأم

****Don't handle the cord too much as handling → vasoconstriction**

2-Put woman on the trolley in Knee-chest position (to raise the presenting part), even you may elevate the presenting part with your hand (through vagina) till reaching the operation room

3-Listen again to FHS

4-Cesarean Section as fast as possible في فتحة مشرط واحدة
